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Michigan's Nursing Home Reform Law

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MICHIGAN'S NURSING HOME REFORM LAW

One in five of the nation's elderly will spend some time in a long-term care facility.[1] The purpose of a long-term facility is to provide the requisite nursing or personal care to patients who do not need hospital care. Most states differentiate between types of long-term care facilities according to the type of care rendered with different names for each type.[2] In Michigan, facilities

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[1] Kastenbaum & Candy, *The Four Per Cent Fallacy*, 4 AGING & HUMAN DEV. 15 (1973); Lesnoff-Caravaglia, *The Five Per Cent Fallacy*, 9 AGING & HUMAN DEV. 187 (1978); Palmore, *Total Chance of Institutionalization Among the Aged*, 16 GERONTOLOGIST 504 (1976). Six percent of the population over sixty-five are in nursing homes at any particular time. *Id.*

[2] Some state statutes differentiate among long-term care facilities according to the following levels of care: (1) facilities providing 24 hour skilled nursing care; (2) facilities providing supportive nursing care; and (3) facilities providing supervision and personal services. Iowa's statute is typical:

> 1. "Residential care facility" means any institution, place, building, or agency providing for a period exceeding twenty-four consecutive hours accommodation, board, personal assistance and other essential daily living activities to three or more individuals, . . . who do not require the services of a registered or licensed practical nurse except on an emergency basis.
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> 2. "Intermediate care facility" means any institution, place, building, or agency providing for a period exceeding twenty-four consecutive hours accommodation, board, and nursing services . . . to three or more individuals . . . who by reason of illness, disease, or physical or mental infirmity require nursing services which can be provided only under the direction of a registered nurse or a licensed practical nurse.
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> 3. "Skilled nursing facility" means any institution, place, building, or agency providing for a period exceeding twenty-four consecutive hours accommodation, board, and nursing services . . . to three or more individuals . . . who by reason of illness, disease, or physical or mental infirmity require continuous nursing care services and related medical services, but do not require hospital care. The nursing care services provided must be under the direction of a registered nurse on a twenty-four-hours-per day basis.

IOWA CODE ANN. § 135C.1 (West Supp. 1979). *See also* KAN. STAT. ANN. § 39-923 (Supp. 1979); MD. HEALTH CODE ANN. art. 43, § 566B (1971); MO. ANN. STAT. § 198.006 (Vernon Supp. 1980); MONT. REV. CODE ANN. § 69-5201 (Supp. 1977); NEB. REV. STAT. § 71-2017.01 (1976); NEV. REV. STAT. §§ 449.014, 449.018 (1977); *and* OKLA. STAT. ANN. tit. 63, § 1-801 (West 1973).

Other state statutes differentiate only among those facilities providing nursing care and those facilities providing only supervision and personal services. Tennessee's is representative:

> (d) "Nursing home" means any institution, place, building or agency repre-

providing no more than supervised personal care are called "homes for the aged";[3] facilities providing organized nursing care and medical treatment are termed "nursing homes."[4]

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sented and held out to the general public for the express or implied purpose of providing care for one or more nonrelated persons who are not acutely ill, but who do require skilled nursing care and related medical services. The term "nursing home" shall be restricted to facilities providing skilled nursing care and related medical services to individuals, beyond the basic provision of food, shelter and laundry, admitted because of illness, disease or physical infirmity for a period of not less than twenty-four (24) hours per day.

(e) "Home for the aged" means a home represented and held out to the general public as a home which accepts aged persons for relatively permanent, domiciliary care. A home for the aged provides room, board, and personal services to one or more nonrelated persons. . . .

TENN. CODE ANN. § 53-1301(d) & (e) (Supp. 1977). *See also* ILL. ANN. STAT. ch. 111½, § 35.16 (Smith-Hurd 1977); MASS. ANN. LAWS ch. 111, § 71 (Michie/Law Group Supp. 1980); N.C. GEN. STAT. § 130-9 (Supp. 1979); OHIO REV. CODE ANN. § 3721.01 (Page Supp. 1979); PA. STAT. ANN. tit. 62, § 1001 (Purdon 1968); S.D. COMP. LAWS ANN. § 34-12-1 (1977); W. VA. CODE § 16-5C-2 (1979); *and* WIS. STAT. ANN. § 50.01 (West Supp. 1979).

Another group of states do not differentiate among long-term care facilities. For example, the California statute provides:

"Long-term health care facility" means any [licensed] facility . . . which (1) maintains and operates 24-hour skilled nursing services for the care and treatment of chronically ill or convalescent patients, including mental, emotional, or behavioral problems, mental retardation, or alcoholism; or (2) provides supportive, restorative, and preventive health services in conjunction with a socially oriented program to its residents, and which maintains and operates 24-hour services including board, room, personal care, and intermitent nursing care. "Long-term health care facility" includes nursing homes, skilled nursing facilities, extended care facilities, intermediate care facilities, and shall not include acute care hospital or other licensed facilities except for that distinct part of such hospital or facility which provides nursing home, skilled nursing facility, extended care facility, or intermediate care facility services.

CAL. HEALTH & SAFETY CODE § 1418(a) (West 1979). *See also* ARIZ. REV. STAT. ANN. § 36-446(5) (West Supp. 1979); ARK. STAT. ANN. § 82-2216(a) (Supp. 1979); CONN. GEN. STAT. ANN. § 19-602 (West Supp. 1980); DEL. CODE ANN. tit. 16, § 1201(3) (1974); IDAHO CODE § 39-3301(1) (1977); IND. CODE ANN. §16-10-2-3(a) (Burns Supp. 1979); KY. REV. STAT. ANN. § 216.510(1) (Supp. 1979); LA. REV. STAT. ANN. § 40:2009.2(1) (West 1977); MINN. STAT. ANN. § 144A.01 (subd. 5) (West Supp. 1980); MISS. CODE ANN. § 43-11-1(a) (Supp. 1979); N.J. STAT. ANN. § 30:13-2(c) (West Supp. 1979); N.Y. PUB. HEALTH LAW § 2801 (McKinney 1977); UTAH CODE ANN. § 26-15-65 (1976); VA. CODE § 32.1-123(2) (1979); WASH. REV. CODE ANN. § 18.51.010 (1978); *and* WYO. STAT. § 35-2-101 (1977).

The names of long-term care facilities may vary fom state to state. *See, e.g.*, Boarding home for the aged and infirm (N.D. CENT. CODE § 50-18-01 (Supp. 1979)), Home for the Aged (*e.g.*, ILL. ANN. STAT. ch. 111½, § 35.16 (Smith-Hurd 1977)), Home for the Aging (*e.g.*, OHIO REV. CODE ANN. § 3721.01 (Page Supp. 1979)), Institutions for the aged and infirm (MISS. CODE ANN. § 43-11-1(a) (Supp. 1979)), *and* Shelter home (IDAHO CODE § 39-3301(1) (1977)).

[3] A "home for the aged" is defined as "a supervised personal care facility, other than a hotel, adult foster care facility, hospital, nursing home, or county medical care facility, that provides room, board, and supervised personal care to 7 or more unrelated, nontransient, individuals 62 years of age or older." MICH. COMP. LAWS ANN. § 333.20106(3) (West Supp. 1979).

[4] The Michigan nursing home reform law defines a nursing home as "a nursing care

While the quality of care provided in many long-term care facilities is good, reports indicate that high levels of care are far from universal.[5] A significant number of facilities may be guilty of patient abuse and of serious violations that endanger patients' health.[6] Although every state has adopted statutory standards

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facility, including a county medical facility, but excluding a hospital or [a veteran's facility], which provides organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity." *Id.* § 333.20109(1). Nursing homes are included within the terms "health facility or agency" and "skilled nursing facility." *Id.* §§ 333.20106(h), 333.20109(4).

[5] The most comprehensive study of long-term care facilities was undertaken by the United States Senate Subcommittee on Long-Term Care. *See* SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, 93D CONG., 2D SESS., (1974) [hereinafter cited as INTRO. REPORT]. This subcommittee has also published a series of supporting papers that explain in detail the problems outlined in the INTRO. REPORT. *See* SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPERS 1-9, 93D CONG., 2D SESS. (1974). Another comprehensive study was conducted by the Moreland Act Commission of New York State. *See* NEW YORK STATE MORELAND ACT COMM'N ON NURSING HOMES AND RESIDENTIAL FACILITIES, SUMMARY REPORT, LONG TERM CARE REGULATION: PAST LAPSES, FUTURE PROSPECTS (1976) [hereinafter cited as SUMMARY REPORT]; NEW YORK STATE MORELAND ACT COMM'N ON NURSING HOMES AND RESIDENTIAL FACILITIES, REPORT ONE, REGULATING NURSING HOME CARE: THE PAPER TIGERS (1975) [hereinafter cited as THE PAPER TIGERS]. The most recent comprehensive study of conditions in nursing homes was conducted by the AFL-CIO. *See* AFL-CIO, NURSING HOMES AND THE NATION'S ELDERLY: AMERICA'S NURSING HOMES-PROFIT IN HUMAN MISERY, Statement and Report Adopted by the AFL-CIO Executive Council, Bar Harbour, Florida (1977) (*reprinted in Hearings before the House Subcomm. on Oversight and Investigations of the Comm. on Interstate and Foreign Commerce,* 95th Cong., 1st Sess. (1977) [hereinafter cited as AFL-CIO REPORT].

See also Calif. Assembly Comm. on Health, Interim Hearing, Nursing Homes in California 3-4 (Nov. 1977).

The reports reveal shocking abuses of patients in many nursing homes. The most common abuses of patients in nursing homes include: neglect by the staff; the failure to prevent bed sores and muscular contractures; the excessive use of physical restraints; the use of violence against patients; the use of chemical tranquilizers for staff convenience; and the failure to provide bed pans when necessary. In addition, unwholesome or spoiled food may be served, the staff may be untrained or inadequate, and heat, linen, and blankets may be insufficient. Theft and misappropriation of patients' money and property may occur and excessive charges may be assessed. Finally, there may be reprisals against those who complain. SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 1, THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY 163, 169-204, 93d Cong., 2d Sess. (Comm. Print 1974) [hereinafter cited as LITANY OF ABUSES]; THE PAPER TIGERS, *supra* at 3; AFL-CIO REPORT, *supra* at 7-11.

[6] *See generally* authorities cited in note 5 *supra*. The Subcommittee on Long-Term Care stated that 50% of nursing homes had violations that endangered patients' health but noted that some reports placed this figure even higher. LITANY OF ABUSES, *supra* note 5, at 205-09. The AFL-CIO report stated that while their inspections "did not confirm the 50% estimate, they uncovered serious violations in a number of inspected homes and brought forward a number of individuals with serious allegations concerning uninspected homes." AFL-CIO REPORT, *supra* note 5, at 7.

for nursing homes with penalties for non-compliance,[7] inadequate standards and ineffective enforcement procedures have hampered effective regulation in the past.[8] Recently, several states have responded to the exposés of nursing home abuses by enacting nursing home reform laws.

This article examines Michigan's new nursing home reform law,[9] which has been hailed as "landmark legislation" and as a model for the entire country.[10] Part I examines the past failures of nursing home regulation and the need for reform. Part II analyzes the law's key provisions. Part III examines the weaknesses of certain enforcement measures. The article proposes the following improvements: (1) extension of the law's protection to residents of homes for the aged; (2) greater access to patients by approved organizations; (3) adoption of nurse-patient ratios; (4) improvement of inspection procedures; and (5) allowance for patients or their representatives to initiate receiverships proceedings.

I. THE PAST FAILURES OF NURSING HOME REGULATION

The enforcement of nursing home standards has been termed a "national farce."[11] The reasons most frequently given for the failure of the enforcement process are the lack of adequate inspections, the permissive attitude of state health departments, and the lack of effective enforcement procedures.[12] The state agencies empowered to enforce nursing home standards rely on inspections to determine whether the standards are being met. In the past, inspections of nursing homes tended to be of the "brick and mortar" type, concentrating on the standards for

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[7] For the pertinent provisions of the state statutes, see APPENDIX A.

[8] *See generally* M. MENDELSON, TENDER LOVING GREED (1974); F. MOSS & V. HALAMANDARIS, TOO OLD, TOO SICK, TOO BAD: NURSING HOMES IN AMERICA (1977) [hereinafter cited as F. MOSS]; NADER STUDY GROUP, REPORT OF NURSING HOMES, OLD AGE: THE LAST SEGREGATION (1971); Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304 (1975); Note, *New York's Revised Nursing Home Legislation*, 9 U. MICH. J.L. REF. 375 (1976); Comment, *Regulation of Nursing Homes—Adequate Protection for the Nation's Elderly?*, 8 ST. MARY'S L.J. 309 (1976); Comment, *Governmental Regulation of Nursing Homes—An Inquiry*, 1973 UTAH L. REV. 270.

[9] MICH. COMP. LAWS ANN. §§ 333.21701 - .21799e (West Supp. 1979) (nursing homes); *id.* §§ 333.21301 - .21333 (homes for the aged). Additionally, pt. 201 of art. 17 of the Michigan Public Health Code, *id.* §§ 333.20101 - .20211, contains sections applicable to nursing homes and homes for the aged. The Michigan nursing home reform law is incorporated into the new Michigan Public Health Code.

[10] Detroit News, Nov. 15, 1978, § B, at 10, col. 13; Detroit News, Dec. 7, 1978, § B, at 2, col. 3.

[11] F. Moss, *supra* note 8, at 147.

[12] *See* note 8 *supra*.

physical facilities rather than the quality of care rendered by the nursing homes.[13] Advance notice to the home which is to be inspected has further undermined the inspection process.[14] Although this advance notice assures that key members of the nursing home staff will be present for necessary interviews with the inspector,[15] it also allows ample opportunity to disguise any defects for the inspection. Less than one-third of the states presently require unannounced inspections of nursing homes.[16]

When violations are uncovered, the enforcement process often fails.[17] Enforcement failures may be due in part to the political connections maintained by some nursing home owners[18] and to

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[13] *Nursing Home and Alternative Care Hearing, Hearings Before the Calif. Leg. Joint Comm. on Aging* 37, 121 (1973) [hereinafter cited as *Nursing Home and Alternative Care Hearing*]; INTRO. REPORT, *supra* note 5, at 80-81. Inspections may concentrate on physical standards rather than standards of care because the regulations emphasize structural standards. For example, the Deputy Attorney General of California stated before hearings held by a state legislative committee in 1973 that

> the California Department of Health presently believes that existing law permits it to adopt only regulations relating to a physical plant, its safety and sanitation. The Department has not adopted any regulations really directed to the quality of patient care and believes it is without authority to enact such regulations. Thus it is quite understandable that over the past 25 or more years the inspection of nursing homes has been oriented to a brick and mortar inspection.

Nursing Home and Alternative Care Hearing, supra, at 122.

[14] INTRO. REPORT, *supra* note 5, at 76-84; Detroit News, Sept. 11, 1977, § C, at 6, col. 1.

[15] Advance notice of inspections has been defended on this ground. *See Nursing Home and Alternative Care Hearing, supra* note 13, at 38.

[16] The only states which require unannounced inspections of nursing homes are: California, CAL. HEALTH & SAFETY CODE § 1421 (West 1979); Connecticut, CONN. GEN. STAT. ANN. § 19-613 (West Supp. 1980); Florida, FLA. STAT. ANN. § 400.19 (Harrison 1979); Iowa, IOWA CODE ANN. § 135c.16 (West Supp. 1979); Kansas, KAN. STAT. ANN. § 39-935 (Supp. 1979); Kentucky, KY. REV. STAT. ANN. § 216.530 (Supp. 1979); Maryland, MD. HEALTH ANN. CODE art. 43, § 561 (1971); Massachusetts, MASS. ANN. LAWS ch. 111, § 72 (Michie/Law Group Supp. 1980); Michigan, MICH. COMP. LAWS ANN. § 333.20155 (West Supp. 1979); Minnesota, MINN. STAT. ANN. § 144A.10 (West Supp. 1980); Missouri, MO. ANN. STAT. § 198.022 (Vernon Supp. 1980); New Hampshire, N.H. REV. STAT. ANN. § 151:6-a (1977); New York, N.Y. PUB. HEALTH LAW § 2803 (1) (McKinney 1977); Rhode Island, R.I. GEN. LAWS ANN. § 23-17-12 (1979); Washington, WASH. REV. CODE ANN. § 18.51.210 (1978); and West Virginia, W. VA. CODE ANN. § 16-5c-9 (1979).

[17] A recent example in Michigan involved the Ridgewood Manor Nursing Home in Grand Rapids. The Michigan Department of Public Health (MDPH) inspected the home on July 31 and August 1, 1979, and noted the following deficiencies: chronic short-staffing, a strong nauseating odor, inadequate attention to patients' personal hygiene, unclean and unsanitary conditions, and poor maintanence of patient records. The MDPH took no enforcement action. In fact, when there was a public airing of complaints against Ridgewood Manor in November, 1979, a report made by one senator states: "The Department seemed more concerned to exonerate the facility than to investigate it thoroughly." Senator Stephen Monsma, Report on Ridgewood Manor Nursing Home at 9 (Feb. 18, 1980) (unpublished report on file with the UNIVERSITY OF MICHIGAN JOURNAL OF LAW REFORM).

[18] The New York Moreland Act Commission, created to study the nursing home industry, reported many connections between the owners of nursing homes and the state's

the fact that regulatory agencies have been "captured" by the nursing home industry.[19] Public attention can, however, affect the permissive attitudes of some state health departments. For example, prior to 1975, the New York State Health Department had not limited or suspended any nursing home's operating certificate, had not moved to revoke or suspend a license, had not referred any violations to the attorney general, and had levied few fines.[20]

In the six month following a series of newspaper reports[21] which exposed abuses in nursing homes, however, the change was dramatic. With no augmentation of statutory or regulatory authority and with minor increases in inspection and enforcement staff, the New York State Health Department prepared over sixty cases for fines, initiated proceedings to revoke operating certificates for three facilities, referred ten cases to the Attorney General, and began investigations to determine whether revocation of the licenses of twelve nursing home administrators was warranted.[22] As the New York example illustrates, state agencies may be less prone to lax enforcement when under intense public scrutiny.

Another reason for laxity in the enforcement of nursing home standards by state agencies is that often the only effective enforcement measures other than the assessment of civil or criminal fines are the draconian measures of revocation or sus-

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politicians. *See generally* NEW YORK STATE MORELAND ACT COMM'N ON NURSING HOMES AND RESIDENTIAL FACILITIES, REPORT THREE, POLITICAL INFLUENCE AND POLITICAL ACCOUNTABILITY: ONE FOOT IN THE DOOR (1976). In hearings held in New York, nursing home inspectors testified that their critical reports on substandard homes had been supressed by superiors. The inspectors revealed that they were ordered to "focus on the positive," no matter how bad conditions were. N.Y. Times, Jan. 8, 1975, at 1, col. 1. The Senate Subcommittee on Long-Term Care reported that there were many instances where the recommendations of inspectors were ignored. INTRO. REPORT, *supra* note 5, at 80.

[19] For a discussion of the "capture" theory in connection with the regulation of nursing homes, see Butler, *Assuring the Quality of Care and Life in Nursing Homes: The Dilemma of Enforcement*, 57 N.C. L. REV. 1317, 1327-29 (1979). Because of its years of contact with the regulated industry a captured agency becomes less vigilant in protecting the public's interest.

For further discussion of this theory, see M. BERNSTEIN, REGULATING BUSINESS BY INDEPENDENT COMMISSION 25-49 (1955); Jaffe, *The Effective Limits of the Administrative Process: A Reevaluation*, 67 HARV. L. REV. 1105 (1954); Navarro, *Social Class, Political Power, and the State*, 1 J. HEALTH POL., POL'Y & L. 256 (1976); Posner, *Theories of Economic Regulation*, 4 BELL J. ECON. & MANAGEMENT SCI. 335 (1974).

[20] THE PAPER TIGERS, *supra* note 5, at 6.

[21] *See* N.Y. Times, Oct. 7, 1974, at 1, col. 1; N.Y. Times, Oct. 8, 1974, at 48, col. 1; N.Y. Times, Oct. 9, 1974, at 85, col. 1; N.Y. Times, Oct. 10, 1974, at 42, col. 4; N.Y. Times, Nov. 15, 1974, at 38, col. 1.

[22] THE PAPER TIGERS, *supra* note 5, at 6.

pension of the nursing home's license.[23] State agencies are reluctant to initiate license suspension or revocation procedures for two principal reasons. First, the procedures are often unwieldy and time consuming because many agencies lack sufficient attorneys and other resources and because nursing homes may attempt delay.[24] Second, patients may be displaced if the nursing home is closed.[25] There may not be enough available beds to accommodate the displaced patients, and even when relocation is possible, the patients' health may suffer.[26] Given this reluctance to close nursing homes, promises by the homes to correct violations are often sufficient to postpone enforcement indefinitely.[27]

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[23] For a list of the state statutes providing civil and criminal fines, see APPENDIX B.

[24] In Michigan, prior to the reform law, it took an average of 540 days for the MDPH to litigate charges against a nursing home. Detroit News, Feb. 16, 1977, § A, at 11, col. 1.

[25] The 1970 Report to the Governor of Michigan on Nursing Home Problems states:

> This enforced wholesale movement of patients can cause great inconvenience and actual physical harm to these patients. Thus, revocation of license adversely affects the very people the government seeks to secure. For this reason alone, revocation of license must be used only in severe situations when correction of facility inadequacies is demonstrably not forthcoming and the potential harm to the patients caused by enforced transfer is less than the potential harm to the patients if allowed to stay in the facility persisting in the uncorrected deficiencies.

F. Moss, *supra* note 8, at 160.

In August, 1978, prior to the adoption of the reform law, an official of the Michigan Department of Social Services was quoted as saying: "If we close a place down, . . . we have the very practical problem of placing perhaps 200 elderly residents somewhere else, with all the trauma that creates for them. Bad as a place may be, nine out of 10 residents would rather stay than be moved." Detroit News, Aug. 10, 1978, § A, at 1, 20, col. 5.

Dr. John Cashman, Director of the Ohio Department of Health, noting that his department knew that many inspectors did not do their job properly and that too many homes were in violation, stated, "[W]hat did people want the department to do, turn 24,000 patients out into the street by closing all the homes that have violations?" M. MENDELSON, *supra* note 8, at 31.

[26] Several studies have indicated that extra-institutional movement of nursing home patients can be extremely dangerous. A University of Michigan study reported that among elderly persons forced to transfer from one institution to another, the mortality rate increased significantly—sometimes as much as 100%. *Death Rates Rise for Nursing Home Patients*, AGING 34 (Sept.-Oct. 1977). *See also* Aldrich & Mendkoff, *Relocation of the Aged and Disabled: A Mortality Study*, 11 J. AM. GERIATRICS SOC'Y 185 (1963); Lieberman, *Relocation Research and Social Policy*, 14 GERONTOLOGIST 494 (1974). *But see* Borup, Gallego & Heffernan, *Relocation and its Effect on Mortality*, 19 GERONTOLOGIST 135 (1979), which reports that relocation of nursing home patients does not increase the probability of mortality.

[27] The Health Haven Nursing Home in Detroit, Michigan illustrates how enforcement may be delayed. After inspections had uncovered violations, Health Haven was notified that the state intended to deny the nursing home's license in June 1973. After a series of administrative hearings and appeals that took almost five years, the home was ordered to close as of May 1, 1978. But at a meeting on April 20, 1978, the board of directors of Health Haven adopted a resolution authorizing a program to correct the violations. This action resulted in the staying of the closure order. Detroit News, Aug. 10, 1978, § A, at 1,

II. THE MICHIGAN NURSING HOME REFORM LAW

The provisions of the Michigan nursing home reform law can be divided into two main groups, those setting standards of care designed to prevent abuses and those which deal with enforcement. Because past experience indicates that public enforcement is insufficient,[28] the Michigan legislation provides for both private and public enforcement.

A. Standards of Care and Protection from Abuses

In response to the wide range of abuses suffered by nursing home patients, the Michigan reform law now requires that the contract between a patient and nursing home contain a "patients' bill of rights."[29] This bill of rights most importantly guarantees the patient adequate and appropriate care and freedom from mental and physical abuse. The nursing home must give the patient a copy of the bill of rights when the patient is admitted[30] and must post the bill of rights at a public place in the

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col. 5.

[28] *See* notes 16-31 and accompanying text *supra*.

[29] MICH. COMP. LAWS ANN. § 333.21766(7)(f) (West Supp. 1979). Nursing home patients have the right to: appropriate care without bias; inspection of their medical records; confidential treatment; privacy; information on their medical condition unless medically contraindicated; refusal of treatment; presentation of grievances and advocation on their own behalf; information on experimental procedures with the right of refusal to participate; examination of the billing and information about financial assistance; information on continuing health needs and alternate care; private meetings with a doctor, lawyer and others, as well as the right to send and receive mail unopened; freedom from mental and physical abuse and from physical and chemical restraint, except those restraints authorized in writing by the attending physician; freedom from performing non-therapeutic services for the facility; information about facility rules and regulations and a copy of the rights policy upon admission; association and communication in private with persons of choice; retention and use of personal possessions; help in planning their medical treatment; transfer and discharge protections; management of their financial affairs; treatment by a licensed member of the healing arts; visitors twenty-four per day if terminally ill; meals for special needs; and meetings with patient advocates. If a patient has been adjudicated incompetent, the preceding rights are granted to a person designated by the patient. The facility must provide forms for the patient to provide for the designation of this person at the time of admission. *Id.* § 333.20201.

[30] *Id.* § 333.21765(2); furthermore, for those patients "unable to read the form" the statute requires that

> it shall be read to the patient in a language the patient understands. In the case of a mentally retarded individual, the rights shall be explained in a manner which that person is able to understand and the explanation witnessed by a third person. In the case of a minor or a person having a legal guardian, both the patient and the parent or legal guardian shall be fully informed of the policies and procedures.

Id. § 333.21765(4).

facility.[31] A patient who exercises one of the specified rights cannot be "discharged, harassed, or retaliated or discriminated against" because of the assertion of that right.[32]

Nursing home patients frequently receive inadequate care because the staff employed is often unable, unprepared, or unqualified to give the requisite care. These deficiencies may be due to low pay,[33] a shortage of personnel,[34] or an inadequately trained staff.[35] In an attempt to assure that patients receive appropriate and sufficient care, the reform law requires that each nursing home have as its director of nursing a registered nurse with specialized training or relevant experience in gerontology and at least one licensed nurse on duty at all times.[36] In addition, the ratio of nursing home staff personnel to patients may not exceed eight to one during the morning shift, twelve to one during the afternoon shift, and fifteen to one during the night shift.[37]

A member of the nursing staff is not to be engaged in providing basic services such as food preparation, housekeeping, laundry, or maintenance services.[38] Furthermore, the Michigan Department of Public Health (MDPH) is required to establish rules for the education and training of unlicensed nursing per-

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[31] *Id.* § 333.20201(1).

[32] *Id.* § 333.20201(4).

[33] Nurses' aides and orderlies in Michigan nursing homes are seldom paid much over the minimum wage. Letter from Maurice S. Reizen, Director of MDPH, to Governor Milliken (March 11, 1980) (on file with the UNIVERSITY OF MICHIGAN JOURNAL OF LAW REFORM). Low wages prevail throughout the nation. SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 4, NURSES IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL) xii, 370, 93d Cong., 2d Sess., (Comm. Print 1975) [hereinafter cited as NURSES IN NURSING HOMES]; AFL-CIO REPORT, *supra* note 5, at 15.

[34] Maurice S. Reizen, Director of MDPH, stated that "[s]hortages in nurse staffing is the most serious contributor to deficiencies in nursing care." Letter from Maurice S. Reizen to Governor Milliken (Mar. 11, 1980) (on file with the UNIVERSITY OF MICHIGAN JOURNAL OF LAW REFORM).

[35] NURSES IN NURSING HOMES, *supra* note 33, at 360-64. The result is that nursing homes rely on untrained and unlicensed personnel to provide eighty to ninety percent of the care in nursing homes. *Id.* at xii.

[36] MICH. COMP. LAWS ANN. § 333.21720a(1) (West Supp. 1979). Most nursing home patients require a high level of care and attention. Most are disabled. The average patient has approximately four chronic or crippling diseases; less than fifty percent are ambulatory; at least fifty-five percent are mentally impaired; thirty-three percent are incontinent. INTRO. REPORT, *supra* note 5, at 16-17; F. MOSS, *supra* note 8, at 8.

[37] MICH. COMP. LAWS ANN. § 333.21720a(2) (West Supp. 1979). For a suggestion on improving the ratio of trained nurses to patients, see notes 119-22 and accompanying text *infra*.

[38] MICH. COMP. LAWS ANN. § 333.21720a(2) (West Supp. 1979). An exception is made in the case of a natural disaster or other emergency reported to and concurred in by the MDPH. *Id.*

sonnel and to give random competency exams to determine whether the requirements are being met.[39]

Nursing home staff is prohibited from "physically, mentally, or emotionally abusing, mistreating, or harmfully neglecting a patient."[40] Patients' personal property is protected by the requirement that all patients' funds deposited with the nursing home must be held separately in trust[41] and a periodic accounting is required.[42] Staff members and physicians are required to report instances of abuse.[43] Interference or harrassment against a complainant or the person on whose behalf the action is taken is prohibited.[44]

The potential problem of relocation is somewhat alleviated by the requirement that a patient may be involuntarily transferred or discharged only for medical reasons, the welfare of the patient himself or of the other patients or facility employees, or non-payment.[45] An involuntary transfer or discharge for non-payment must be preceded by a twenty-one-day notice, with the patient having the right to request a hearing.[46] A request for a hearing stays a transfer pending a hearing or appeal decision.[47] If the patient is required to move after the hearing, he cannot be transferred before the expiration of thirty days following receipt of the original notice of the discharge or transfer.[48] If a patient is transferred or discharged, the reform law requires the patient and the patient's family or representative[49] to be consulted in

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[39] MICH. COMP. LAWS ANN. § 333.21795 (West Supp. 1979). No action has yet been taken by the MDPH in promulgating rules. *See* note 137 *infra*. For suggestions on the proper training of aides in nursing homes, see Gilbert, *Training of Aides to the Elderly*, 1 LONG TERM CARE & HEALTH SERVICES AD. Q. 179 (1977).

[40] MICH. COMP. LAWS ANN. § 333.21771(1) (West Supp. 1979).

[41] *Id.* § 333.21721.

[42] *Id.* § 333.21767(2). The accounting must be done at least every three months.

[43] *Id.* § 333.21771(2). Instances of abuse which are reported to the nursing home administrator must in turn be reported immediately to the departments of public health and social services. The law also provides that "[a] physician or other licensed health care personnel of a hospital or other health care facility to which a patient is transferred who becomes aware of an act prohibited by this section shall report the act to the department." *Id.* § 333.21771(4).

[44] *Id.* § 333.21771(6).

[45] *Id.* § 333.21773(1).

[46] *Id.* § 333.21773(2), (3). The 21-day notice requirement does not apply where an emergency transfer or discharge is required by the patient's health, where the physical safety of other patients or employees is in jeopardy, or where the transfer or discharge is subsequently agreed to by the patient or his legal guardian.

[47] *Id.* § 333.21773(4).

[48] *Id.* § 333.21773(3)(c).

[49] A "patient's representative" is defined in the statute as "a person, other than the licensee or an employee or person having direct or indirect ownership interest in the nursing home, designated in writing by a patient or a patient's guardian for a specific,

choosing another facility.[50] The patient must receive counseling prior to the move to minimize "transfer trauma." The MDPH must additionally provide post-transfer or discharge counseling if needed.[51] If a patient is temporarily absent from a nursing home, there is a reasonable expectation that the patient will return, and the nursing home receives payment for the absent period, the nursing home is required to hold the patient's bed open for ten days if he is absent for emergency medical treatment or eighteen days if for therapeutic reasons.[52] When a patient's absence is longer than the specified time, the patient has the option to return to the nursing home for the next available bed.[53]

B. Enforcement Provisions

Private enforcement combined with expanded public enforcement creates the framework for correcting most nursing home abuses. The reform law provides a wide-range of procedures to facilitate enforcement.

1. Private enforcement—The Michigan reform law allows any person to make a written complaint[54] which the MDPH must begin to investigate within fifteen days.[55] A complainant who is dissatisfied with the determination or investigation by the MDPH may request a hearing within thirty days after the mailing of the MDPH's finding.[56] A nursing home employee who is aware of a violation is *required* to report the violation to the nursing home administrator or director.[57] A nursing home administrator or director who becomes aware of a violation is required to report *immediately* the matter by telephone to the MDPH.[58]

In addition to the sections allowing a patient or anyone else to make a complaint that will initiate an investigation by the MDPH, the reform law provides the patient with remedies. For a violation of the patient's "bill of rights," the MDPH is re-

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limited purpose or for general purposes, or if a written designation of a representative is not made, the guardian of the patient." *Id.* § 333.21703(2).

[50] *Id.* § 333.21776.

[51] *Id.*

[52] *Id.* § 333.21777.

[53] *Id.* § 333.21777(3).

[54] *Id.* § 333.21799a(1). The statute provides that "the department shall assist the person in reducing an oral request to a written complaint within 7 days after the oral request is made."

[55] *Id.* §§ 333.20176(1) & .21799a(4).

[56] *Id.* § 333.21799a(9).

[57] *See* note 43 *supra.*

[58] *Id.*

quired to order the nursing home to pay the injured patient one hundred dollars, or to reimburse the patient for costs incurred or injuries sustained, whichever is greater.[59] Since remedies under the reform law are cumulative, not exclusive, a patient may also be able to sue the nursing home in tort for abuses suffered.[60] Additionally, since the reform law requires that the patient's "bill of rights" be specified in every contract between the patient and nursing home,[61] breach of these contract rights may provide patients with a cause of action.

To assist patients in learning and asserting their legal rights, the reform law requires that the nursing home allow a representative of an approved organization access to the nursing home patients.[62] Prior to the new law, access to nursing homes by private groups could only be gained through the courts.[63] Under the new law, an organization desiring access approval must apply to the director of the MDPH, who must approve or disapprove the application with the advice of the nursing home task force.[64] The director is required to approve the organization making the request if it is a bona fide community organization or legal aid program capable of informing patients of their legal rights or assisting patients in asserting their legal rights and likely to "enhance the welfare of nursing home patients."[65] Representatives of approved groups are allowed access to nursing homes during the regular visiting hours each day, but must receive the individual patient's permission to enter his or her private area. The pa-

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[59] MICH. COMP. LAWS ANN. § 333.21799c(3) (West Supp. 1979). In addition, the nursing home is assessed a civil fine, not to exceed $1500 or $15 per patient bed, whichever is less. *Id. See* APPENDIX B.

[60] MICH. COMP. LAWS ANN. § 333.21799e (West Supp. 1979).

[61] *See* note 29 and accompanying text *supra.*

[62] MICH. COMP. LAWS ANN. § 333.21763(1) (West Supp. 1979).

[63] *See generally* Comment, *Nursing Home Access — Making the Patient Bill of Rights Work,* 54 U. DET. J. URB. L. 475, 490-512 (1977).

[64] MICH. COMP. LAWS ANN. § 333.20127 (West Supp. 1979) authorizes a nursing home task force composed of fifteen members: one nurse, one social worker, five representatives of nursing homes, three representatives of public interest, health interest, and consumer groups, and five public members (three of whom shall have or have had relatives in nursing homes). A majority of the task force must be consumers (statutorily defined as non-providers of nursing home services. *Id.* § 333.20104(3)). The responsibilities of the task force include receiving and commenting on drafts of proposed rules, reviewing complaint investigation reports and procedures, and acting as an an appeal body for complaints about access to patients by approved community organizations. *Id.* § 333.20127(6).

The law further provides: "(4) A person aggrieved by the decision of the director may appeal the decision to the nursing home task force. A decision of the task force shall be binding on the director." *Id.* § 333.21764 (footnote omitted).

[65] MICH. COMP. LAWS ANN. § 333.21764(3) (West Supp. 1979).

tient may terminate the visit at any time.[66]

By including in the legislation a statutory right to access by patients' rights groups, Michigan has adopted an innovative and valuable enforcement device.[67] In addition to aiding patients in asserting their legal rights, access to nursing homes by patients' rights groups may provide other positive results. Public inspection and enforcement is supplemented and scrutinized, and there is increased incentive for the enforcement agencies to perform their duties. Moreover, the very presence of the patients' rights groups in the nursing homes should result in improved conditions.[68]

2. *Public enforcement*—The Michigan reform law provides more stringent licensing requirements[69] and an annual renewal

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[66] *Id.* § 333.21763(2). This article proposes an expansion of the access provision. *See* notes 107-12 and accompanying text *infra*.

[67] For a discussion of the importance of access by patients' rights groups, see Regan, *When Nursing Home Patients Complain: The Ombudsmen or the Patient Advocate*, 65 GEO. L.J. 691 (1977). For an argument in favor of patients' rights organizations having access to nursing homes, see Hering, *Nursing Home Watchdogs*, THE PROGRESSIVE, Feb. 6, 1980, at 39. Not all parties view patients' rights groups as a positive force, however. George MacKenzie, Executive Director of the Wisconsin Association of Nursing Homes, has stated: "The relatives and friends of the patients are the real advocates for the patients, and they're needed. But the consumer advocate who just has time on his hands is only looking for trouble." *Id.*

For a list of nursing home patients' rights organizations and a discussion of their activity, see L. HORN & E. GRIESEL, NURSING HOMES: A CITIZEN'S ACTION GUIDE 119-65 (1977).

[68] One commentator has noted:

> To make the point that institutions do a better job when outsiders are constantly coming in and out is *not* to suggest that they maintain their standards only for show. Rather, it is to recognize that we all depend on the interest and appreciation of other people to keep our morale and the quality of our work high. Dressing for dinner in the desert is not a standard most of us could keep to. We tidy the house for the visit of friends because of standards they and we share, and because we want them to appreciate our house as we do.

Barney, *Community Presence as a Key to Quality of Life in Nursing Homes*, 64 AM. J. PUB. HEALTH 265 (1974).

[69] MICH. COMP. LAWS ANN. §§ 333.20152, .20162 & .20165 (West Supp. 1979). When determining whether to issue or re-issue a license, the agency is to consider the past inspection reports of the facility and complaints against it. The agency may refuse to issue a license if the applicant had a previous license revoked during the five years preceding the application or if the applicant is not suitable to operate the facility because of financial incapacity or lack of good moral character or appropriate business or professional experience. *Id.* § 333.21755. In an attempt to control kickbacks, the law requires that an applicant or licensee disclose the names and addreses of all suppliers doing more than $5,000 business per year with the nursing home and additionally requires full disclosure if a nursing home owner or his relative supplies goods or services exceeding $5,000 per year. *Id.* § 333.20142(4). An applicant who makes a false statement in an application is guilty of a felony, punishable by imprisonment for not more than four years, or a fine of not more than $30,000, or both. *Id.* § 333.20142(5). If the agency determines that the nursing home is in compliance with the regulations, it must issue a license. *Id.* § 333.20162(1).

procedure.[70] More effective inspection procedures are also established. Prior to 1974, the MDPH announced inspections of nursing homes.[71] In 1974, the law was changed to require unannounced, annual inspections; the reform law retains this requirement for inspections other than those of financial records.[72] Records and reports of inspections are subject to public disclosure.[73]

The penalty provisions of Michigan's law have also been strengthened. Public employees who give prior notice of inspection, either directly or indirectly, are guilty of misdemeanors.[74] Any person who violates a provision of the nursing home reform law or a regulation or order promulgated under it is guilty of a misdemeanor, punishable by a fine of not more than $1000 *for each day the violation continues.* [75] The per diem fine is important because it not only punishes but also provides an incentive to correct the violation. Since the owner, operator, and governing body of a nursing home are personally responsible for *all* phases of the operation of the nursing home and the quality of care rendered there,[76] penalties may be assessed against them.[77]

The key provisions of the Michigan nursing home reform law are the corrective sanctions, whose purpose is to cure the immediate problem without injury to the patients.[78] When a nursing home does not comply with the standards or regulations, the MDPH may take one or more of the following actions: (a) suspend the admission or readmission of patients to the nursing home; (b) reduce the licensed capacity of the nursing home; (c) selectively transfer patients whose care needs are not being met by the nursing home; (d) initiate action to place the home in receivership; and (e) issue a corrective notice describing the violation and specifying the corrective action to be taken and the

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[70] *Id.* § 333.20164(1).

[71] Detroit News, Sept. 11, 1977, § C, at 6, col. 1.

[72] MICH. COMP. LAWS ANN. §§ 333.20155(1), (2) (West Supp. 1979). Visits merely for consultation may be announced.

[73] *Id.* § 333.21743(6).

[74] *Id.* § 333.20155(2).

[75] *Id.* § 333.20199. This article proposes changing the penalties for non-compliance with sections pertaining to the patient's health, safety, or welfare to civil sanctions. *See* notes 123-29 and accompanying text *infra.*

[76] MICH. COMP. LAWS ANN. § 333.21713(a) (West Supp. 1979).

[77] One exception is for a violation of the patients' "bill of rights": "[a]n *individual* shall not be civilly or criminally liable for failure to comply with" the patients' "bill of rights." However, the nursing home is liable. *Id.* § 333.20203(1).

[78] Agencies are often reluctant to revoke or suspend a home's license for fear that "transfer trauma" will harm the patients. *See* notes 25-26 *supra.*

date by which the violation is to be corrected.[79]

Upon finding that a violation *seriously* affects the health, safety, and welfare of the nursing home patients,[80] the MDPH may, in addition to taking one of stated actions above, limit, suspend, or revoke the nursing home's license.[81] If the MDPH issues an order affecting the license of the nursing home, the MDPH may request the Department of Social Services to limit reimbursements or payments made to the home.[82] If any of these actions regarding corrective sanctions or the home's license are taken, the opportunity for a hearing must be provided, but the hearing does not suspend any of MDPH's orders.[83] The penalties prescribed by the reform law or by a regulation promulgated under it are cumulative and not exclusive.[84] By providing a wide range of enforcement procedures, the reform law gives the responsible agency ability to correct the violations by a nursing home, without forcing the home to close. Previously, the only procedures available to the MDPH were the revocation or suspension of the home's license.[85]

The most effective sanction is potentially receivership.[86] Receivership theoretically allows the forced improvement of nursing home conditions without terminating essential services. Upon either the conclusion of the due process procedures of a

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[79] MICH. COMP. LAWS ANN. § 333.21799c(1) (West Supp. 1979).

[80] The statutory language of *id.* § 333.20168(1) includes the conjunction "and". This language should be amended to read "the health, safety, *or* welfare" of the nursing home patients, in order to conform with other provisions of the reform law, such as the receivership provision, *id.* § 333.21751.

[81] *Id.* § 333.20168(1).

[82] *Id.*

[83] *Id.* § 333.21799b(2). With respect to corrective sanctions, the hearing requirements are: "Within 72 hours after receipt of a notice [of a corrective sanction], the licensee shall be given an opportunity for a hearing on the matter. The [corrective sanction] shall continue in effect during the pendency of the hearing and any subsequent court proceedings."

If the MDPH limits, suspends, or revokes a nursing home's license, the department must provide an opportunity for a hearing within five working days after issuance of the order. The conduct of a hearing under this section does not suspend the department's order. *Id.* § 333.20168.

[84] *Id.* § 333.21799e.

[85] *Id.* §§ 351.651 - .660 (repealed 1978).

[86] *See* Grad, *Upgrading Health Facilities: Medical Receiverships as an Alternative to License Revocation*, 42 U. COLO. L. REV. 419 (1971). Michigan is one of eight states that statutorily provides for receivership for nursing homes. The others are: Connecticut, CONN. GEN. STAT. ANN. § 19-621a to -621i (West Supp. 1980); Kansas, KAN. STAT. ANN. §§ 39-954 to -963 (Supp. 1979); Minnesota, MINN. STAT. ANN. § 144A.15 (West Supp. 1980); Missouri, MO. ANN. STAT. §§ 198.099 - .136 (Vernon Supp. 1980); New Jersey, N.J. STAT. ANN. § 26:2H-42 (West Supp. 1979); New York, N.Y. PUB. HEALTH LAW § 2810 (McKinney 1977); and Wisconsin, WIS. STAT. ANN. § 50.05 (West Supp. 1979).

"contested case"[87] or upon the suspension or revocation of the license of a nursing home, the MDPH, a patient in the nursing home, or a patient's representative may petition for the appointment of a receiver.[88] Where the court finds that the health or safety of the patients in the nursing home would be "seriously threatened" if the condition continued, the court may appoint as receiver the director of a state agency or a person designated by the director of the MDPH.[89] The receiver is directed to use the income and assests of the nursing home to correct the violative conditions, in addition to maintaining and operating the home.[90] The receivership terminates when the receiver and the court certify that the violative conditions have been corrected, when the license is restored or when a new license is issued, or, where the home is no longer in operation, when the patients are safely placed in other facilities, whichever occurs first.[91]

Michigan's receivership provision differs from those of most other states because a receiver may be installed to correct the dangerous conditions *prior* to the completion of a hearing and subsequent appeals,[92] and the receivership is not limited in

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[87] A "contested case" is defined as a "proceeding, including rate-making, price-fixing, and licensing, in which a determination of the legal rights, duties, or privileges of a named party is required by law to be made by an agency after an opportunity for an evidentiary hearing." MICH. COMP. LAWS ANN. § 24.203 (West. Supp. 1979).

[88] *Id.* § 333.21751.

[89] *Id.*

[90] *Id.*

[91] *Id.*

[92] Because a hearing does not delay the suspension or revocation of a license, see note 83 *supra,* immediately upon a finding that the conditions seriously threaten the patients' health or safety, a receiver may be appointed. It is possible that this provision will be attacked on the ground that the appointment of a receiver *prior* to a hearing violates due process of law, but the provision should survive such an attack. In Fuentes v. Shevin, 407 U.S. 67 (1972), the Supreme Court recognized that "extraordinary situations," such as the protection of the public "from misbranded drugs and contaminated food," may justify postponement of a hearing in order to protect important government and public interests. *Id.* at 90-92. One commentator has noted that where nursing home patients' health and safety are seriously threatened "the public has a significant interest in the protection of nursing home residents by prompt appointment of a receiver." Note, *New York's Revised Nursing Home Legislation,* 9 U. MICH. J.L. REF. 375, 387 (1976).

Even if the threat to the patient's health or safety is not deemed to be an "extraordinary situation," the Michigan provision should still be valid. The Supreme Court in Mitchell v. W.T. Grant Co., 416 U.S. 600 (1974), held that a hearing prior to seizure of property is not essential if there has been prior judicial supervision and an immediate post-seizure hearing is provided. The Michigan requirement that a court determine that the patients' health or safety is severely threatened before appointing a receiver, combined with the opportunity for a hearing within five days, should satisfy the *Mitchell* criteria.

But see North Georgia Finishing, Inc. v. Di-Chem, Inc., 419 U.S. 601, 607 (1975), in which the Court distinguished *Mitchell* from a situation in which a bank account was garnished merely upon a writ "issued by a court clerk without notice or opportunity for

time.[93]

III. WEAKNESSES IN THE MICHIGAN NURSING HOME REFORM LAW AND SUGGESTIONS FOR IMPROVEMENTS

The Michigan nursing home reform law confronts the failures of the past and offers workable solutions. Nevertheless, the reform law could be strengthened in several ways.

A. Residents of Homes for the Aged

Michigan's nursing homes are available only to those who are "suffering or recovering from illness, injury, or infirmity."[94] Other senior citizens may reside only in "homes for the aged."[95] Residents of the latter facilities are granted many of the same protections afforded patients in nursing homes, *e.g.*, annual unannounced inspections,[96] stringent licensing standards,[97] criminal sanctions for violations of regualtions,[98] an array of enforcement procedures,[99] and the bill of rights.[100] Not *all* the protec-

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an early hearing and without particpation by a judicial officer."

A nursing home patient may also have the right to a hearing before a nursing home may be closed down. In O'Bannon v. Town Court Nursing, 586 F.2d 280 (1978), *cert. granted*, 47 U.S.L.W. 3683 (1979) (No. 78-1318, 1979 Term), the Supreme Court granted certiorari on the question of whether the due process clause requires that individuals who reside in nursing homes and receive services pursuant to Title XIX of the Social Security Act must be given notice and opportunity for a hearing before that nursing home may be terminated as a qualified provider of services under that act. As of March 1980, the decision of the Supreme Court is pending.

[93] *Cf.* KAN STAT. ANN. § 39-963 (Supp. 1979) (limits the duration of the receivership to 24 months); MINN. STAT. ANN. § 144A.15(5) (West Supp. 1980) (limits the duration of the receivership to 18 months); N.Y. PUB. HEALTH LAW § 2810(2)(e)(i)(a) (McKinney 1977) (limits the duration of the receivership to 18 months); and WIS. STAT. ANN. § 50.05(4) (West Supp. 1979) (limits the duration of the receivership to 90 days).

[94] *See* note 4 *supra*.

[95] *See* note 3 *supra*.

[96] MICH. COMP. LAWS ANN. § 333.20155(1) & (2) (West Supp. 1979).

[97] *See* note 69 *supra*.

[98] *See* note 75 *supra*.

[99] MICH. COMP. LAWS ANN. § 333.20162(5) (West Supp. 1979):

> The department, upon finding that a health facility or agency is not operating in accord with the requirements of its license, may:
>
> (a) Issue an order directing the licensee to:
>
> (i) Discontinue admissions.
>
> (ii) Transfer selected patients out of the facility.
>
> (iii) Reduce its licensed capacity.
>
> (iv) Comply with specific requirements for licensure or certification as appropriate.
>
> (b) Through the office of the attorney general, initiate misdemeanor proceedings against the licensee as provided in section 20199(1).

[100] *See* note 29 *supra*.

tions granted nursing home patients, however, are extended to residents of homes for the aged. The bill of rights, which should be effective for nursing home patients,[101] may prove rather hollow for residents in homes for the aged. There is no requirement that the bill of rights be specified in the contract between the resident and the home for the aged.[102] Furthermore, in contrast to a nursing home patient, a resident in a home for the aged is not given a statutory remedy for a violation of the bill of rights.[103] A resident could sue in tort for abuses suffered, but would most likely have to do so without the assistance of a representative of a residents' rights organization. There is no statutory procedure for the approval of such organizations to gain access to homes for the aged. The bill of rights theoretically guarantees a resident the right to communicate with persons of his choice,[104] yet without a statutory provision allowing access to homes for the aged, it is unlikely that residents' rights organizations will easily gain access to homes for the aged.[105] Since many of the abuses which are present in nursing homes also occur in homes for the aged,[106] residents of the latter should be afforded the same protections given nursing home patients.

B. Access to Nursing Home Patients by Patients' Rights Groups

Even when access to nursing home patients by patients' rights groups is required,[107] the proviso that the representative receive an individual patient's permission prior to entering a patient's living area[108] may prevent access to those patients who, by reason of sedation or mental illness, are unable to give their permission. The practice of excessive sedation of nursing home patients

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[101] *See* notes 29-32 and accompanying text *supra*.

[102] MICH. COMP. LAWS ANN. § 333.21766(7)(f) (West Supp. 1979) requires that a patient-*nursing home* contract contain the "bill of rights." There is no similar requirement for a resident-*"home for the aged"* contract.

[103] *See* note 59 and accompanying text *supra*. There is no corresponding statutory remedy for residents of homes for the aged.

[104] MICH. COMP. LAWS ANN. § 333.20201(2)(k) (West Supp. 1979).

[105] One commentator suggests that a nursing home which wishes to prevent access may tell outsiders that a patient may see only persons "of his choice," *i.e.*, persons he has specifically asked to see in advance. Gassel, *Nursing Home Law*, in LAW OF THE ELDERLY 213-14 (J. Weiss ed. 1977).

[106] NATIONAL ASS'N OF ATTYS. GEN., COMM. ON THE OFFICE OF ATTY. GEN., ENFORCING QUALITY OF CARE IN NURSING HOMES 7 (1978).

[107] *See* notes 62-66 and accompanying text *supra*.

[108] *See* note 66 *supra*.

is widespread[109] and has been referred to by a Senate subcommittee as the "chemical straightjacket."[110] The patient's bill of rights guarantees freedom from chemical restraints except those authorized by a physician,[111] yet it would be naive to believe that this provision alone will correct the problem. Organizations that have been approved by the state to assist patients in asserting their right to be free from abuses should not, however, be barred by those very abuses. A provision which allows the patient to *refuse* admittance to a representative would protect the patient's privacy but still allow access to those patients highly susceptible to abuse.[112]

C. *Inspections*

While patients' rights groups have access to nursing homes and can report any observed violations of the nursing home law,[113] the MDPH depends on its own inspections. The Michigan reform law requires that inspections be unannounced so that nursing homes cannot make cosmetic improvements in anticipation of inspections.[114] The Michigan legislature indicated its concern about advance notice of inspections by providing criminal penalties for any public employee who directly or indirectly gives advance notice.[115] Nonetheless, these statutory protections are insufficient. In a hearing held before the Joint Committee on Aging of the Michigan legislature, witnesses reported that the MDPH routinely makes its unannounced inspections immediately prior to the time licenses come up for renewal.[116] Nursing homes consequently know in which month the unannounced in-

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[109] *See generally* SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 2, DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS AND KICKBACKS, 93D CONG., 2D SESS. (Comm. Print 1975) [hereinafter cited as DRUGS IN NURSING HOMES].

[110] *Id.* at 268. The evidence before the Senate Subcommittee on Long-Term Care indicated that patients were given excessive amounts of drugs, especially tranquilizers, in order to keep them quiet to the point of being comatose. *Id.* at 268-74.

[111] MICH. COMP. LAWS ANN. § 333.20201 (2)(l) (West Supp. 1979).

[112] A similar provision is found in the Georgia code regarding the meeting of patients with an ombudsman. "The State ombudsman or community ombudsman shall identify himself as such to the resident, and the resident shall have the right to communicate or refuse to communicate with the ombudsman." GA. CODE ANN. § 88-1906a(c) (Supp. 1979).

[113] *See* notes 54 & 62-66 and accompanying text *supra*.

[114] *See* note 72 and accompanying text *supra*.

[115] *See* note 74 and accompanying text *supra*.

[116] *Hearing before the Michigan Legislature Joint Committee on Aging* (Feb. 25, 1980) (proposed minutes on file with the UNIVERSITY OF MICHIGAN JOURNAL OF LAW REFORM).

spections will be and, from past experience, know it will be within the first two weeks of that month.[117] In one particular case, the MDPH made its unannounced inspection on the same day of the annual announced inspection.[118] Inspections should either be made at random or conducted monthly so that deficiencies are quickly recognized.

D. Nursing Home Staff

Two of the most serious problems in the nursing home industry are the reliance on untrained and unlicensed personnel and the lack of a sufficient number of personnel. The Michigan nursing home reform law attempts to alleviate these problems. The law requires that each nursing home have as its director of nursing a registered nurse with specialized training or relevant experience in gerontology and at least one licensed nurse on duty at all times.[119] In addition, the reform law requires staffing ratios.[120] Finally, minimum criteria for the education and training of unlicensed personnel are to be established and random exams given to determine whether the requirements are being met.[121] Notwithstanding these provisions, the Michigan law does not address the crux of the problem: reliance on untrained and unlicensed personnel. The personnel included in the staffing ratios may be composed of nurses *and* untrained and unlicensed personnel. While the ratio requirement attempts to assure a minimum of *personnel* for every patient, such a ratio sets no standard for the number of *nurses* per patient. Thus, the nursing home can satisfy the staffing requirements by having only one registered nurse among the requisite number of personnel. There is no assurance that the other personnel are trained, because the statute specifically states that the minimum standards of education and training are not prerequisites for employment in a nursing home.[122]

To alleviate the problem of reliance upon untrained and unlicensed personnel, a nurse-patient ratio should be adopted which relates the minimum number of nurses on duty to the size of the nursing home. The present requirement of one licensed nurse on

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[117] *Id.*

[118] *Id.* The nursing home was the Ridgewood Manor Nursing Home in Grand Rapids, Michigan. *See* note 17 *supra.*

[119] MICH. COMP. LAWS ANN. § 333.21720a(1) (West Supp. 1979).

[120] *Id.* § 333.21720a(2).

[121] *Id.* § 333.21795.

[122] *Id.*

duty at all times should be retained as a minimum. Furthermore, the minimum standards established by the MDPH for the education and training of unlicensed personnel should be prerequisites for employment in a nursing home.

E. Criminal and Civil Sanctions

To enforce the nursing home reform law, Michigan has primarily chosen criminal sanctions: a misdemeanor with a one thousand dollar per diem penalty for any violation[123] and more severe criminal penalties for certain specific violations.[124] A civil fine is assessed for violations of the patients' bill of rights, including the right to receive "adequate and appropriate care."[125]

The aim of enforcement of provisions pertaining to the health, safety, or welfare of the patients should be the speedy *correction* of the violations. The criminal nature of a penalty, however, may inhibit quick correction of deficiencies. Violations must be proven beyond a reasonable doubt, a difficult burden when the recipients of the abuse are often mentally ill, senile, or confused.[126] The substantial trial delays available to the defendants and the cost of prosecution may result in few cases being prosecuted.[127] The Michigan nursing home reform law properly provides a civil sanction for a violation of the patients' bill of rights, but does not go far enough. This civil assessment is a "one-shot" fine.[128] After the nursing home has been cited, there is no further incentive to comply with the law, as would be the case with a per diem fine.

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[123] *Id.* § 333.20199.

[124] If a person operates a nursing home without a license or under a misleading name, abuses or harmfully neglects a patient, or retaliates against a person making a complaint, he is guilty of a misdemeanor, punishable by imprisonment for not more than one year or a fine of not less than $1000, but not more than $10,000. *Id.* § 333.21799c(1). The reform law makes kick-backs for referral of patients or for the purchase of drugs or services felonies, punishable by imprisonment for not more than four years, or a fine of not more than $30,000, or both. *Id.* § 333.21792.

[125] *Id.* § 333.20201(2)(a)-(n), 3(a)-(e), § 333.20201(2)(e).

[126] The Senate Subcommittee on Long-Term Care reported that at least fifty-five percent of nursing home residents are mentally impaired. INTRO. REPORT, *supra* note 5, at 17. In an essay advising state attorneys general how to prosecute nursing homes for criminal violations, an assistant attorney general of Alabama warned: "You may have to use some recipients [patients], but we've found they're very difficult to work with. They're old and frequently their memories are bad." Kendrick, *Trial Preparation (Nursing Homes)*, in NATIONAL ASS'N OF ATTYS. GEN., COMM. ON THE OFFICE OF ATTY. GEN., ATTORNEYS GENERAL'S APPROACHES TO PROBLEMS OF HEALTH CARE 63, 64 (1978).

[127] One commentator has even claimed that judges do not regard these violations as criminal and are reluctant to impose jail sentences or large fines. Brown, *supra* note 8, at 354.

[128] *See* note 59 *supra*.

To further the speedy correction of the violation, the civil assessment should include a per diem fine in addition to the basic fine. There might conceivably be deficiencies that immediately threaten the health, safety, or welfare of the patients, but which do not constitute violations of the patients' bill of rights. A civil per diem assessment in such a situation may promote quicker correction of the dangerous violations than would the criminal sanctions now provided. In addition, the fine should be assessed even when the violations have been subsequently corrected. Otherwise a nursing home may violate the law until it is caught and then correct the situation without any penalty being exacted. In order to encourage payment of the fine interest on the amount should be levied from the date the fine is due.[129] A hearing procedure should be established so that persons desiring to contest assessments are granted due process.

Where violations do not immediately threaten the health, safety, or welfare of the patients, the deterrent and punitive impact of criminal sanctions might be better employed.[130] In these circumstances the prime concern is not the speedy correction of a dangerous condition, but obedience to the law. Thus, the Michigan nursing home reform law should retain its criminal penalties for violations of licensing standards, disclosure requirements, unannounced inspections, and other violations which do not immediately threaten the health, safety, or welfare of patients.

F. Receivership

Receivership is available for the correction of violations which seriously threaten the health or safety of patients.[131] While the Michigan receivership provision has advantages over the receivership provisions of some other states,[132] it can be improved. The provision allows a nursing home patient or a patient's representative to apply for the appointment of a receiver, but only

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[129] The Michigan reform law already provides a procedure for collecting civil fines. If the party does not pay the fine to the MDPH within 30 days, the Department presently has the option of either having the amount of the fine deducted from the state reimbursement to the home or adding the amount of the civil penalty to the nursing home's licensing fee. MICH. COMP. LAWS ANN. § 333.21799(d) (West Supp. 1979).

[130] For example, while a public employee who gives advance notice of inspections to nursing homes may be willing to incur a civil fine, especially if remuneration from the nursing home more than offsets his loss, he might not be as willing to face the stigma of a criminal indictment or conviction.

[131] *See* notes 86-93 and accompanying text *supra*.

[132] *See* notes 92-93 and accompanying text *supra*.

after the MDPH has concluded the due process procedures of a "contested case" or after the MDPH has suspended or revoked the nursing home's license.[133] In effect, this places sole control of application for receivership in the hands of the MDPH.

There are compelling reasons for allowing patients or their representatives to apply for receivership independently of action taken by the MDPH.[134] The New Jersey receivership provision allows a patient to apply for receivership by filing a complaint alleging that the facility is in substantial violation of the health, safety, or patient care standards of federal law or state law or "any other conditions dangerous to life, health or safety," or that the facility habitually violates those standards.[135] A similar result can be achieved in Michigan by eliminating the requirement that the MDPH either conclude the due process procedures of a "contested case" or revoke or suspend a facility's license before the MDPH, patient, or patient's representative can apply for receivership.[136]

G. Standards and Regulations[137]

The Michigan nursing home reform law provides a framework for the effective enforcement of the nursing home standards and regulations. Patients will not be assured of adequate care, however, unless the standards and regulations that are being enforced pertain to patient care. In the past, health departments have adopted a "structural" approach to the promulgation of

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[133] *See* note 88 *supra*.

[134] While the availability of receivership should alleviate fears of patient relocation, see note 25 and accompanying text *supra*, agencies may still be reluctant to initiate license suspension or revocation because of the time and expense involved. One commentator cites the example of Colorado, where the attempt to revoke the license and Medicaid certification of a nursing home involved an administrative hearing of 20 days, 4000 pages of testimony and exhibits, over $10,000 in legal expenses, and more than a year's delay in final agency action. The judicial review of the state's order is expected to add to the cost and delay. Butler, *supra* note 19, at 1350 n.161. Additionally, a "captured" agency may be reluctant to initiate license revocation or suspension proceedings. *See* note 19 and accompanying text *supra*.

[135] N.J. STAT. ANN. § 26:2H-36, -38 (West Cum. Supp. 1977). The Missouri receivership provision allows a resident or his guardian to petition for the appointment of a receiver when an "emergency exists in the facility." MO. STAT. ANN. § 198.099 (Vernon Supp. 1980).

[136] This change would additionally allow the MDPH to apply for receivership without first initiating license revocation or suspension proceedings. *Cf.* KAN. STAT. §§ 39-954 to -963 (Cum. Supp. 1978) (allowing the state to seek receivership whenever conditions exist that threaten resident health or safety).

[137] The MDPH was to propose rules by September, 1979. MICH. COMP. LAWS ANN. § 333.21741(2) (West Supp. 1979). However, as of March 1980 the MDPH has not submitted proposed rules to a public hearing.

regulations which is concerned only with the physical facilities.[138] Clearly, compliance with structural regulations cannot determine whether the care actually rendered is sufficient.[139] Consequently, the reform law specifically requires the MDPH to establish standards relating to patient care.[140]

A system must be developed to assess the quality of care rendered and to determine whether these standards are being met. The relatively homogeneous nursing home population and the readily observable and controlled nature of the patients' lives provide amenable conditions for creating a system through which the quality of care can be assessed.[141] In reviewing New York's nursing home law, for example, the Moreland Act Commission proposed a system to assess the adequacy of care provided by nursing homes.[142] The system presented consisted of four stages: (1) standards are developed which set the minimally-acceptable diagnostic, treatment, and follow-up procedures for ailments or conditions common to many nursing home patients; (2) non-physician inspection staff then extract pertinent information from patient charts, provided these standards are reasonably specific; (3) the quality of care is assessed by analyzing the differences between actual practice and the standards; and (4) deviations from minimally acceptable practice are documented for further assessment by the enforcement agency's medical staff and for the application of the appropriate measures.[143] While the generality of such a system has inherent problems,[144] this system or one like it provides a better measure

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[138] *See* note 13 *supra*. For examples of Michigan's structural regulations, see MICH. ADMIN. CODE §§ 325.2011-.2038.

[139] A New York study found that there was no correlation between the structural standards ratings and the quality of care provided. THE PAPER TIGERS, *supra* note 5, at 42.

[140] MICH. COMP. LAWS ANN. § 333.21741(a)(f) (West Supp. 1979).

[141] Regan, *Quality Assurance Systems in Nursing Homes*, 53 J. URB. L. 153, 239-40 (1975).

[142] SUMMARY REPORT, *supra* note 5, at 32-39, 88-151.

[143] For a similar recommendation see Regan, *supra* note 141, at 237-41. *See also* Butler, *supra* note 19, at 1331-37. One commentator has suggested recently that a certain amount of work under such a system could be performed by computers, thus possibly reducing costs and freeing inspectors to perform other tasks. *Id.* at 1335, 1381-82.

[144] There are a number of problems associated with the group method of evaluating end-results. Death may be the only reported outcome, because knowledge of the natural history of the illness or of the patient's symptoms or activity level may be unavailable when the patient dies. Similarly, in the case of living patients, relevant data may not be recorded in the patient's chart and must be obtained from a patient interview. Even where the medical factors can be identified, social and economic factors may also affect a patient, and thus the precise impact of the medical factors cannot be evaluated. Nor can evaluation "depend upon long-term outcome measurements, such as death from hypertensive disease, but instead must depend upon less certain, short-term outcomes such as

of the quality of patient care and should be adopted in Michigan.

CONCLUSION

The effectiveness of the Michigan nursing home reform law depends upon the degree to which it is enforced. Enforcement agencies should be more willing to enforce the laws now that they are provided with a wide range of corrective sanctions and are supplemented and spurred by the patients' rights organizations. Adoption of the following suggestions made in this article would result in an even stronger nursing home law:

(1) all of the protections afforded patients in nursing homes should be extended to residents in "homes for the aged";
(2) representatives of an approved patients' rights group should be allowed to meet with an individual patient unless the patient refuses;
(3) a nurse staffing ratio related to the size of the facility should be required;
(4) a system for monitoring patient care should be developed to supplement the traditional standards;
(5) unannounced inspections should be randomized or made monthly;
(6) patients or their representatives should be allowed to apply for receivership independently of action taken by the enforcement agency; and
(7) civil, not criminal, per diem penalties should be assessed for violations which threaten the health, safety, or welfare of nursing home patients.

The Michigan law is not a panacea. It does not claim to affect what may well be the underlying problem—our society's aversion to aging and the aged.[145] The focus of the Michigan nursing home reform law has been on correcting the deficiencies of past laws, rather than on dealing with the problems nursing homes

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blood pressure control." Finally, physicians have not been taught to think in terms of group prognosis.

Regan, *supra* note 141, at 239 (citations omitted) (citing Brook, *Critical Issues in the Assessment of Quality of Care and Their Relationship to HMO's*, 48 J. MED. ED. 114 (1973)).

[145] One researcher has described our society as gerontophobic. Bunzel, *Recognition, Relevance and Deactivation of Gerontophobia*, 21 J. AM. GERIACTRICS SOC'Y 73, 73-80 (1973).

and the entire health care system face in the near future.[146] By adopting innovative public and private enforcement procedures, Michigan has enacted a law which has the potential to correct the failures of the past. Standards for the adequate care of nursing home patients must not be enforced, however, only when the public is awakened by reports of abuses. Adoption of the suggestions made in this article may result in a nursing home law which remains effective even when public attention has turned elsewhere—a true measure of success for any nursing home law.

—John D. Croll

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[146] See Butler, *Nursing Home Care: An Impossible Situation Unless . . .*, 8 INT'L J. AGING & HUMAN DEV. 291, 291-92 (1977):

> Demand and cost lines on charts point toward an impossible situation. The health care system in this country is in crisis and this crisis is reflected in the inadequately met needs of our elderly for nursing home care. . . .
>
> Demand for services increase as the number of old people grows, and at the same time they insist on more and better services. Costs increase as demand increases and the inflation spiral continues. . . .
>
> Nevertheless, to cut back or deny services to those that need them is unthinkable; to accept an ever-increasing burden of cost is intolerable. Alternatives to nursing home care and cost-containment are imperative.

Among the alternatives which the author suggests are: financial aid to families to enable them to provide for their old; new prosthetics to permit severely handicapped people to move about and lead independent lives; preventive medicine; the training of pharmacologists and physicians in the special needs of the elderly and geriatrics; and research on the diseases that force people into institutions. *Id.* at 292-94.

APPENDIX A

The pertinent state statutes are: ALA. CODE §§ 34-20-1 to -16, §§ 22-21-20 to -33 (1977); ALASKA STAT. §§ 08.70.010-.180 (1977); ARIZ. REV. STAT. ANN. §§ 36-401 to -432 (1974) & 36-446 to -446.09 (Supp. 1979); ARK. STAT. ANN. §§ 82-2201 to -2225 (1976 & Supp. 1979); CAL. BUS. & PROF. CODE §§ 3901 - 3950 (West 1974 & Supp. 1977) & CAL. HEALTH & SAFETY CODE §§ 1417 - 1439 (West 1979); COLO. REV. STAT. ANN. §§ 12-39-101 to -117 (1978), 25-1-120 to -121 (Supp. 1978), & §§ 12-13-101 to -117 (1978); CONN. GEN. STAT. ANN. §§ 17-135a to -135m & §§ 19-591 to -626 (West Supp. 1979); DEL. CODE ANN. tit. 16, §§ 1101 - 1110, 1201 - 1213 (1974) & §§ 1121 - 1125 (Supp. 1978); FLA. STAT. ANN. §§ 400.011 - .333 (West 1979) & 468.1635 - .1775 (West Supp. 1978); GA. CODE ANN. §§ 84-4901 to -4913 & §§ 88-1901 to -1912 (1979); HAWAII REV. STAT. § 321-11(10) (Supp. 1978) & §§ 457B-1 to -12 (1976); IDAHO CODE §§ 39-3301 to -3309 (1977) & §§ 54-1601 to -1616 (1979); ILL. ANN. STAT. ch. 111½, §§ 35.16 - .31 & ch. 111, §§ 3601 - 3633 (Smith-Hurd 1977 & Supp. 1979); IND. CODE ANN. §§ 16-10-2-1 to -19 & §§ 25-19-1-1 to -12 (Burns 1976 & Supp. 1979); IOWA CODE ANN. §§ 135C.1 - .48 (West 1972 & Supp. 1979-80); KAN. STAT. ANN. §§ 39-923 to -963 & §§ 65-3501 to -3508 (Supp. 1979); KY. REV. STAT. ANN. §§ 216.405 - .530 & §§ 216A.010 - .990 (Baldwin 1977 & Supp. 1978); LA. REV. STAT. ANN. §§ 37:2501 - :2511 (West 1974) & §§ 40:2009.1 - .19 (West 1977 & Supp. 1979); ME. REV. STAT. ANN. tit. 22, §§ 1811 - 1824 (Supp. 1965 - 1979); MD. HEALTH CODE ANN. art. 43, §§ 556-568 (1971) & art. 703, § 5 (1978 & Supp. 1979); MASS. ANN. LAWS ch. 111, §§ 71 - 73 (Michie/Law Co-op Supp. 1979) & ch. 112, §§ 108-117 (Michie/Law Co-op 1975 & Supp. 1979); MICH. COMP. LAWS ANN. §§ 333.21701 - .21799e (West Supp. 1979); MINN. STAT. ANN. §§ 144A.01 - .611 (West. Cum. Supp. 1979); MISS. CODE ANN. §§ 43-11-1 to -27 (1972 & Cum. Supp. 1979) & §§ 73-17-1 to -15 (1972); MO. ANN. STAT. §§ 198.003 - .445 (Vernon 1972 & Supp. 1980) & §§ 344.010 - .100 (Vernon Cum. Supp. 1979); MONT. REV. CODES ANN. §§ 69-5201 to -5224 (1970 & Supp. 1975) & §§ 82A-1602.17 - .18 (Supp. 1977); NEB. REV. STAT. §§ 71-2017 to -2029 (1976); NEV. REV. STAT. §§ 449.001 - 24 (1977) & §§ 654.010 - .200 (1977); N.H. REV. STAT. ANN. §§ 151:1 - :18 (1977 & Supp. 1977) & §§ 151-A:1 - :11 (Supp. 1977); N.J. STAT. ANN. §§ 30:11-1 TO -28 (WEST 1964 & SUPP. 1979) & §§ 30:13-1 TO -11 (WEST SUPP. 1979); N.M. STAT. ANN. §§ 61-13-1 to -16 (1978); N.Y. PUB. HEALTH LAW §§ 2800 - 2811, 2895-2898 (McKinney 1977); N.C. GEN. STAT. §§ 90-275.1

to -288 (1975) & §§ 130-264 to -277 (Cum. Supp. 1979); N.D. CENT. CODE §§ 43-34-01 to -14 (1978 & Supp. 1979) & §§ 50-18-01 to -08 (1974 & Supp. 1979); OHIO REV. CODE ANN. §§ 3721.01 - .99 (Page 1971 & Supp. 1978) & §§ 4751.01 - .99 (Page 1977 & Supp. 1979); OKLA. STAT. ANN. tit. 63, §§ 1-801 to -861 & §§ 330.21 to -.60 (West 1973 & Supp. 1979); ORE. REV. STAT. §§ 442.015 - .450 & §§ 678.710 - .990 (1977); PA. STAT. ANN. tit. 62, §§ 1001 - 1031 (Purdon 1968 & Supp. 1979) & tit. 63, §§ 1101 - 1114 (Purdon Supp. 1979); R.I. GEN. LAWS ANN. §§ 5-45-1 to -13 (1976 & Supp. 1979), & §§ 23-17-1 to -25, §§ 17.2-1 to -7, -17.5-1 to -23 (1979); S.C. CODE ANN. §§ 40-35-10 to -140 (1976), & §§ 43-28-10 to -60 (Supp. 1978), -29-10 to -80, -37-10 to -20 (1976 & Supp. 1978); S.D. CODIFIED LAWS ANN. §§ 34-12-1 to -22 & §§ 36-28-1 to -28 (1977 & Supp. 1979); TENN. CODE ANN. §§ 53-1301 to -1330 (1977 & Cum. Supp. 1979) & §§ 63-1601 to -1613 (1976 & Cum. Supp. 1979); TEX. REV. STAT. ANN. arts. 4442c - 4442d (Vernon 1976 & Supp. 1979); UTAH CODE ANN. §§ 26-15-65 to -78 (1976 & Supp. 1979); VT. STAT. ANN. tit. 18, §§ 2001 - 2015 (1968 & Cum. Supp. 1979), 2051 - 2061 (Supp. 1979); VA. CODE ANN. §§ 32.1-123 to -138 (1979) & §§ 54-899 to -907 (1978 & Supp. 1979); WASH. REV. CODE ANN. §§ 18.51.005 - .900, .52.010 - .900 (1978 & Supp. 1978); W. VA. CODE ANN. §§ 16-5C-1 to -17 (1979) & §§ 30-25-1 to -11 (Supp. 1979); WIS. STAT. ANN. §§ 50.001 - .11 (West 1957 & Supp. 1979), §§ 150.001 - .48 (West 1974 & Supp. 1979) & §§ 456.01 - .11 (West 1974 & Supp. 1979); WYO. STAT. ANN. §§ 33-22-101 to -112, §§ 35-2-101 to -604 (1977).

APPENDIX B

Most states provide one of four kinds of penalties: *Criminal "One Shot" Penalties: see* Alaska, ALASKA STAT. §08.70.170 (1977) (fine of not more than $500, or imprisonment for not more than one year, or both); Colorado, COLO. REV. STAT. ANN. § 25-1-114 (1978) (fine of not more than $1000 and up to one year in prison); Hawaii, HAWAII REV. STAT. § 321-18 (1976) (fine of not more than $500 or imprisonment for not more than one year, or both); Maine, ME. REV. STAT. ANN. tit. 22, § 1821 (Supp. 1965-1979) (fine of not more than $100 or imprisonment for not more than 90 days); North Dakota, N.D. CENT. CODE § 50-18-08 (1974 & Supp. 1979) (misdemeanor fine); Tennessee, TENN. CODE ANN. § 53-1329 (1977 & Cum. Supp. 1979) (misdemeanor fine where violation was willful); Vermont, VT. STAT. ANN. tit. 18, § 2013 (1968 & Cum. Supp. 1979) (fine of not more than

$500); *and* Wyoming, WYO. STAT. ANN. § 35-2-112 (1979) (fine not to exceed $100); *Criminal Per Diem Penalties*: *see* Arizona, ARIZ. REV. STAT. ANN. § 36-431 (1974) (misdemeanor offense, with per diem sanctions of $100, for a knowing violation); Idaho, IDAHO CODE § 39-3307 (1979) (fine of not more than $300 per day and up to six months in prison); Illinois, ILL. ANN. STAT. ch. 111½, § 35.29 (Smith-Hurd 1977) (fine of not more than $1000 per day); Indiana, IND. CODE ANN. § 16-10-2-14 (Burns 1976 & Supp. 1979) (fine of not more than $100 per day); Louisiana, LA. REV. STAT. ANN. § 40:2009.11 (West 1977 & Supp. 1979) (fine of not less than $25 nor more than $100 per day); Michigan, MICH. COMP. LAWS ANN. § 333.20199 (West Supp. 1979) (fine of no more that $1000 per day); Mississippi, MISS. CODE ANN. § 43-11-25 (1972) (fine of no more than $100 per day); Nebraska, NEB. REV. STAT. § 71-2028 (1976) (fine of not more than $100 the first day and not more than $500 each following day); New Hampshire, N.H. REV. STAT. ANN. § 151:16 (per diem misdemeanor); South Carolina, S.C. CODE ANN. § 43-28-60 (Supp. 1978) (fine of not more than $100 the first day and not more than $500 each following day); Texas, TEX. REV. STAT. ANN. art. 4442c, § 12 (Vernon 1976 & Supp. 1979) (if the nursing home is operated after suspension or revocation of the home's license, a fine of not more than $200 for the first day and a fine of not more than $100 each following day); *and* Washington, WASH. REV. CODE ANN. § 18.51.150 (1978 & Supp. 1978) (if the nursing home is operated after suspension or revocation of the home's license, a per diem misdemeanor penalty is assessed); *Civil "One Shot" Penalties: see* Florida, FLA. STAT. ANN. § 400.23 (West 1979) (a class "I" violation is subject to a penalty of not less than $1000 nor more than $5000, a class "II" violation is subject to a penalty of not less than $50 nor more than $250, a class "III" violation is subject to a penalty of not less than $20 nor more than $50); Ohio, OHIO REV. CODE ANN. § 3721.99 (Page 1971 & Supp. 1978) (fine of $100 for a first offense, fine of $500 for each subsequent offense); *and* Rhode Island, *R.I. Gen. Laws Ann.* § 23-17-12.3 (1979) (fine of no more than $300); *Civil Per Diem Penalty: see* Alabama, ALA. CODE § 22-21-33 (Cum. Supp. 1978) ($25 per day); Arizona, ARIZ. REV. STAT. ANN. § 36-431.01 (Supp. 1979) (fine of not more than $300 per day); California, CAL. HEALTH & SAFETY CODE §§ 1424, 1425 (West 1979) (a class "A" violation is subject to a fine of not less than $1000 nor more than $5000, a class "B" violation is subject to a fine of not less than $50 nor more than $250; if the violation is not corrected within the time specified, an additional $50 per diem fine is assessed); Connecti-

cut, CONN. GEN. STAT. ANN. § 19-610 (West Supp. 1979) (a class "A" violation is subject to a penalty of not less than $3000 nor more than $5000 per day, a class "B" violation is subject to a penalty of not less than $1000 nor more than $3000 per day, a class "C" violation is subject to a penalty of not less than $500 nor more than $1000 per day, and a class "D" violation is subject to a penalty of not less than $100 nor more than $500 per day); Iowa, IOWA CODE ANN. §§ 135C.36, 135C.40 (West Supp. 1979-80) (a class "I" violation is subject to a penalty of not less than $500 nor more than $5000, a class "II" violation is subject to a penalty of not less than $100 nor more than $500, a class "III" violation is subject to a per diem penalty of $50; if the class "I" and "II" violations are not corrected within the time specified, a $50 per diem fine is assessed); Kansas, KAN. STAT. ANN. § 39-946 (Supp. 1979) (a penalty not to exceed $100 per day); Massachusetts, MASS. ANN. LAWS ch. 111, § 73 (Michie/ Law Co-op Supp. 1979) (a penalty not to exceed $500 for a first offense and $1000 for each subsequent offense. Each day the facility does not comply with the correction order constitutes a subsequent offense); Minnesota, MINN. STAT. ANN. § 144A.10 (West Cum. Supp. 1979) (a penalty not to exceed $250 per day); Missouri, Mo. ANN. STAT. § 198.067 (Vernon Supp. 1980) (penalty of up to $100 for each day that noncompliance continues after the notice of non-compliance is received); New Jersey, N.J. STAT. ANN. § 30:11-26 (West 1964 & Supp. 1979) (if the nursing home is operated after suspension or revocation of the home's license, a $50 per diem fine is assessed for the first offense and a $100 per diem fine is assessed for subsequent offenses); New York, N.Y. PUB. HEALTH LAW § 2803(6) (McKinney 1977) (penalty not to exceed $1000 per day); Pennsylvania, PA. STAT. ANN. tit. 62, § 1031 (Purdon 1968 & Supp. 1979) (if the nursing home is operated after suspension or revocation of the home's license, a fine of not less than $25 nor more than $300 per day); West Virginia, W. VA. CODE ANN. § 16-5C-10 (1979) (a class "I" violation is subject to a penalty of not less than $100 nor more than $1000 per day, a class "II" violation is subject to a penalty of not less than $50 nor more than $100 per day, a class 'III" violation is subject to a penalty of not less than $25 nor more than $50 per day); *and* Wisconsin, WIS. STAT. ANN. § 50.04(4), (5) (West 1957 & Supp. 1979) (a class "A" violation is subject to a forfeiture of not less than $1000 nor more than $5000 per day, a class "B" violation is subject to a forfeiture of not less than $100 nor more than $1000 per day, and a class "C" violation is subject to a forfeiture of not less than $10 nor more than $100 per day; if

the violation is not corrected within the time specified the following additional per diem fines are assessed: $5000 for class "A" violations; $1000 for class "B" violations; and $100 for class "C" violations).